VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

REMICADE.1
FORM#23
C: 12.14

Agency of Human Services

~REMICADE~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for Remicade, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

Prescribing physician:

Name: _____
Phone#:_____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ Sex: _____
Pharmacy Name_____
Pharmacy Phone: _____Pharmacy Fax: _____

Will this medication be billed through the: **pharmacy benefit** or **medical benefit** (J-code or other code)? **(Please check one)**

Please check box if this drug is being provided under the DVHA's 340B Drug program

Administering Provider/Facility if other than Prescriber: (name):_____ NPI#_____

Remicade Infusion: Pt weight: _____ (kg) Dose:_____ ____ (mg/kg) Total Dose: _____ (mg)

Frequency:_____Length of therapy:_____

Indication: Crohn's Disease Ulcerative Colitis Rheumatoid Arthritis Ankylosing Spondylitis

Psoriasis (Plaque) Psoriatic Arthritis

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date (s) attempted
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please explain why self-injectables (if indicated but not trialed) cannot be trialed?

_____

Prescriber comments:_____

_____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature:_____ Date of request:_____

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